Sub-Chapter 15

Utilization Rules and Non-Hospital Fee Schedules

24.29.1501 PURPOSE (1) The purpose in developing utilization rules is to assure that appropriate quality and cost effective medical services are available to individuals injured on the job. Health care programs outside the workers' compensation arena such as the federal medicare and medicaid programs, as well as private health insurers, have had medical cost containment measures in place for some time. While reimbursement for medical services will continue to be based on fee schedules, the need for cost containment measures similar to those implemented in the non-workers' compensation area has been recognized. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93.)

Rules 24.29.1502 and 24.29.1503 reserved

24.29.1504 DEFINITIONS As used in this subchapter, the following definitions apply:

(1) "Documentation" means written information that is complete, clear, and legible, which describes the service provided and substantiates the charge for the service.

(2) "Functional status" means written information that is complete, clear, and legible, that identifies objective findings indicating the claimant's physical capabilities and provides information about the change in the status as a result of treatment.

(3) "Improvement status" means written information that is complete, clear, and legible, which identifies objective medical findings of the claimant's medical status with respect to the treatment plan.

(4) "Medical equipment and supplies" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with associated non-durable materials required for use in conjunction with the device or appliance.

(5) "Objective medical findings" means medical evidence that is substantiated by clinical findings. Clinical findings include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not considered objective medical findings.

(6) "Physician" means those persons identified by 33-22-111, MCA, practicing within the scope of the providers' license.

(7) "Prior authorization" means that for those matters identified by ARM 24.29.1517 the provider receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that procedure.

(8) "Provider" means any health care provider, unless the context in another rule clearly indicates otherwise. "Provider" does not include pharmacists nor does it include a supplier of medical equipment who is not a health care provider.

(9) "Treating physician" has the meaning provided by ARM 24.29.1511 for claims arising before July 1, 1993, and the meaning provided by 39-71-116(29), MCA (1993) for claims arising on or after July 1, 1993.

(10) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. The treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities that will be employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate that treatment is to be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider in the selection of the most appropriate method of treatment; however, the treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02.)

Rules 24.29.1505 through 24.29.1509 reserved

24.29.1510 SELECTION OF PHYSICIAN FOR CLAIMS ARISING ON OR AFTER JULY 1, 1993 (1) For claims arising on or after July 1, 1993, "treating physician" has the meaning provided by 39-71-116(29), MCA (1993).

(2) The worker has a duty to select a treating physician. Initial treatment in an emergency room or urgent care facility is not selection of a treating physician. The selection of a treating physician must be made as soon as practicable. A worker may not avoid selection of a treating physician by repeatedly seeking care in an emergency room or urgent care facility. The worker should select a treating physician with due consideration for the type of injury or occupational disease suffered, as well as practical considerations such as the proximity and the availability of the physician to the worker.

(3) Selection of the treating physician, referrals made by the treating physician, and changes of treating physician must all be made in accordance with the provisions of 39-71-1101, MCA (1993). (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 2809, Eff. 12/1/93.)

24.29.1511 SELECTION OF PHYSICIAN FOR CLAIMS ARISING BEFORE JULY 1, 1993 (1) Although 33-22-111, MCA, provides freedom of choice in selection of a physician, workers' compensation and occupational disease case law also recognizes that a worker must select a single physician who is responsible for the overall medical management of the workers' condition. That physician is known as the treating physician. For claims arising before July 1, 1993, the worker may select any person licensed as one of the following providers as that worker's initial "treating physician";

(a) physician;
(b) physician assistant-certified;
(c) dentist;
(d) osteopath;
(e) chiropractor;
(f) optometrist;
(g) podiatrist;
(h) psychologist; or
(i) acupuncturist.

(2) The worker has a duty to select a treating physician. Initial treatment in an emergency room or urgent care facility is not selection of a treating physician. The selection of a treating physician must be made as soon as practicable. A worker may not avoid selection of a treating physician by repeatedly seeking care in an emergency room or urgent care facility. The worker should select a treating physician with due consideration for the type of injury or occupational disease suffered, as well as practical considerations such as the proximity and the availability of the physician to the worker. A worker must obtain prior authorization before changing treating physician.

(3) Only the treating physician may refer an injured worker to another provider. The treating physician remains responsible for the overall medical management of the injured worker, despite the referral. If the treating physician transfers that responsibility to another physician, the physician loses the status of being the worker's "treating physician" and will not be able to make referrals. Prior authorization is required for change of treating physician. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93.)

Rule 24.29.1512 reserved

24.29.1513 DOCUMENTATION REQUIREMENTS (1) When a treating physician, emergency room or similar urgent care facility sees the claimant for the first time (related to the claim), the provider must furnish to the insurer the initial report and treatment bill within seven business days of the visit. Although the department has pre-printed forms for the first report of treatment available, an insurer and provider may agree to use any other form or format for reporting the first treatment.

(2) As soon as possible, upon completion of the initial diagnostic process, the provider must prepare a treatment plan and promptly furnish a copy to the insurer. Changes in the overall treatment plan must be noted and a copy of the amended treatment plan must be promptly furnished to the insurer.

(3) To be eligible for payment for subsequent visits, the provider must furnish to the insurer:

(a) documentation;

(b) improvement status with respect to the treatment plan; and

(c) office notes with the bill every 30 days.

(4)(a) Certain treatment plans may require services be obtained from a vendor that is outside the tradition of being a professional health care provider. Under that circumstance, the treating physician has the obligation to include the need for the service in the treatment plan and furnish improvement status as appropriate. The vendor, however, is responsible for furnishing documentation.

(b) The following are examples of services that are contemplated as falling within the meaning of this subsection:

(i) health club membership; and

(ii) home health care services.

(5) Documentation is considered to be a service to the injured worker and no charge is allowed for the documentation required by this rule.

(6) The physician should report immediately to the insurer the date total disability ends or the date the injured worker is released to return to work. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff 4/1/94.)

Rule 24.29.1514 reserved

24.29.1515 IMPROVEMENT STATUS (1) Improvement status must identify objective medical findings of the claimant's medical status, and note the effect of the medical services (positive, neutral, or negative), with respect to the goals of the treatment plan.

(2) If there are any significant changes in the treatment plan, that fact must be noted and described. (History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-704 MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93.)

Rule 24.29.1516 reserved

24.29.1517 PRIOR AUTHORIZATION (1) When prior authorization is required, the provider must request the authorization a reasonable amount of time in advance of the time the procedure is scheduled to be performed. The request must contain enough information to allow the insurer to make an informed decision regarding authorization. The insurer may not unreasonably withhold its authorization. An insurers' denial must contain an explanation of the reasons for its denial. Reasonableness will be judged in light of the circumstances surrounding the medical procedure and the claim.

(2) If a provider makes a written request for prior authorization at least 14 days prior to the date the service is scheduled to be performed, authorization is presumed to be given by the insurer if there is no written denial sent by the insurer to the provider within 14 days of the date the written request was mailed. If the written denial is made within 3 days of the expiration of the 14 day response period, the insurer must also notify the provider of the denial by telephone or facsimile ("fax").

(3) If a provider makes a verbal request for prior authorization, the burden of proof for showing that authorization was granted by the insurer rests with the provider. The provider should promptly send to the insurer a written confirmation of any verbal authorization made by the insurer. Such written confirmation should refer not only to the name of the claimant, the claim number, and the procedure authorized, but also the name of the person giving the authorization and the date the authorization was given.

(4) Prior authorization is required when:

(a) the provider to whom the referral is made is a consulting specialist; or

(b) there is a request for change of treating physician; or

(c) the claimant has not been treated for the injury (or occupational disease) within the past 6 months; or

(d) the claimant has been identified as having reached maximum medical improvement; or

(e) any of the following is proposed:

(i) non-emergency surgery;

(ii) an MRI or CT, if the same body part has been imaged within the last 12 months;

(iii) psychological counselling, other than provided by the treating physician;

(iv) membership in a health club;

(v) any pain clinic program;

(vi) pain medication is being prescribed for a period of six months or longer;

(vii) medical equipment and supplies if over $300.00;

(viii) a permanent change from one provider's specialty practice to the specialty practice of a different provider, for treatment of the same injury. The occasional and temporary change of provider due to illness, vacation, or emergency, does not require prior authorization; or

(ix) for any other procedure that by rule specifically requires prior authorization.

(5) For any service identified in (4)(e), additional authorization is required if the duration or extent of the service is later modified because of a change in the treatment plan.

(6) Prior authorization is not required for emergency procedures. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02.)

Rule 24.29.1518 reserved

24.29.1519 SECOND OPINIONS (1) The insurer may request a second opinion from a qualified provider as to whether the following services or procedures are reasonable, necessary, or well-advised:

(a) pain clinics;

(b) non-emergency surgery; or

(c) psychological counselling.

(2) Nothing in this rule affects the right of an insurer to obtain an independent medical examination as provided by the workers' compensation and occupational disease acts.

(3) For the purpose of this rule, a qualified provider is one who is board-certified or board-eligible in a specialty that is reasonably related to the service or procedure for which the second opinion is sought. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93.)

Rule 24.29.1520 reserved

24.29.1521 MEDICAL EQUIPMENT AND SUPPLIES

(1) Reimbursement for provider supplied medical equipment and supplies is limited to the lesser of $30.00 or 30% above the cost of the item including freight, except prescription medicines are limited to charges allowed under 39-71-727, MCA. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(2) If a provider adds value to medical equipment or supplies (such as by complex assembly, modification, or special fabrication) then the provider may charge a reasonable fee for those services. Merely unpacking an item is not a "value-added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable.

(3) This rule does not apply to equipment supply houses that are not also health care providers, hospitals, or pharmacies. (History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-704 MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93.)

Rules 24.29.1522 through 24.29.1525 reserved

24.29.1526 DISALLOWED PROCEDURES (1) Only reasonable and necessary medical expenses are payable. Procedures that are not generally accepted by the medical community may be determined not to be "reasonable" or "necessary". Providers are encouraged to seek prior approval from the insurer for experimental or controversial procedures.

(2) Disputes arising over payment of medical services may be appealed pursuant to 39-71-704, MCA and, when applicable, ARM 24.29.1404.

(3) Medical services which are not payable include, but are not limited to, the following:

a) thermography;
b) autologous cultured chondrocyte for implantation procedures except when it is performed on the knee; and
c) endoscopic spinal procedure.

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24.29.1531 USE OF FEE SCHEDULES FOR SERVICES PROVIDED FROM APRIL 1, 1993 THROUGH JUNE 30, 2002 (1) The department's annual schedule of fees for medical non-hospital services is known as the Montana Workers' Compensation Medical Fee Schedule and is effective for services provided from April 1, 1993 through June 30, 2002. The fee schedule is comprised of the following:

(a) The relative value scales given in the most current edition of the Relative Values for Physicians (RVP), published by systemetrics/mcgraw-hill to be used by doctors of medicine, doctors of podiatry, and doctors of osteopathy, for the following specialty areas:

(i) surgery;

(ii) anesthesia;

(iii) radiology;

(iv) pathology; and

(v) medicine.

(b) The relative unit values provided by the department in separate fee schedules developed for medical non-hospital services provided by the following health care providers:

(i) acupuncture;

(ii) dental;

(iii) occupational therapy;

(iv) physical therapy; and

(v) chiropractic.

(c) Relative values have not been developed for nurse specialists, physicians assistants-certified, optometrists, psychologists, licensed social workers, or licensed professional counselors. These providers must charge reasonable fees for medical services.

(d) The conversion factors as established by the department.

(2) Copies of Relative Values for Physicians are available from the publisher. Ordering information may be obtained from the department.

(3) Relative Values for Physicians uses procedure codes listed in the copyrighted publication known as Current Procedure Terminology, or CPT, published by the American medical association. The edition in effect at the time the medical service is furnished shall be used to determine the proper procedure code, unless a special code or description is provided by rule.

(4) Interim unit values given in Relative Values for Physicians (designated by a box and the letter "I") are included in the fee schedule and are used to calculate maximum fees payable.

(5) Unit values given in the Relative Values for Physicians section titled "HCPCS Codes" are not included in the fee schedule; services listed in this section are considered to

have unit values of "RNE" (relativity not established) for purposes of maximum fee calculation.

(6) All instructions, definitions, guidelines, and other explanations given in the most current edition including updates of the RVP, affecting the determination of individual fees, except as specifically revised or deleted by the department apply.

(7) Revisions to the conversion factors contained in the Medical Fee Schedule become effective January 1. An insurer is not obligated to pay more than the fee provided by the Medical Fee Schedule for a service. The conversion factor in effect on the date the service is provided must be used to calculate the fee.

(8) The maximum fee that an insurer is required to pay for a particular procedure is computed by the unit value times the conversion factor. Use the conversion factor approved by the department for each specialty area. For example, if the conversion factor is $5.00, and a procedure has a unit value of 3.0, the most that the insurer is required to pay the provider for that procedure is $15.00.

(9) Where a procedure is not covered by these rules, the insurer must pay a reasonable fee, not to exceed the usual and customary fee charged by the provider to non-workers' compensation patients.

(10) Where a unit value is listed as "BR", it means that the fee is calculated on a "by report" basis. The fee charged is to be reasonable, and may not exceed the usual and customary fee charged by the provider to non-workers' compensation patients.

(11) It is the responsibility of the provider to use the proper procedure code(s) on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 1659, Eff. 8/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02.)

24.29.1532 USE OF FEE SCHEDULES FOR SERVICES PROVIDED ON OR AFTER JULY 1, 2002 (1) The department's schedule of fees for medical non-hospital services is known as the Montana Workers' Compensation Medical Fee Schedule. Effective July 1, 2002, the fee schedule in this rule is hereby adopted. The fee schedule is comprised of the following:

(a) The relative value scales given in the most current edition of the Relative Values for Physicians (RVP), published by ingenix inc. to be used by doctors of medicine, doctors of podiatry, doctors of osteopathy, doctors of chiropractic, and practitioners licensed as occupational therapists and physical therapists for the following specialty areas:

(i) surgery;
(ii) anesthesia;
(iii) radiology;
(iv) pathology;
(v) medicine;
(vi) chiropractic;
(vii) occupational therapy; and
(viii) physical therapy.

(b) The relative unit values provided by the department in separate fee schedules developed for medical non-hospital services provided by the following health care providers:

(i) acupuncture; and
(ii) dental.

(c) The conversion factors as established by the department.

(2) Relative values have not been developed for nurse specialists, physicians assistants-certified, optometrists, psychologists, licensed social workers, or licensed professional counselors.

(3) Copies of Relative Values for Physicians are available from the publisher. Ordering information may be obtained from the department.

(4) Relative Values for Physicians uses procedure codes listed in the copyrighted publication known as Current Procedure Terminology, or CPT, published by the American medical association. The edition in effect at the time the medical service is furnished shall be used to determine the proper procedure code, unless a special code or description is provided by rule.

(5) Interim unit values given in Relative Values for Physicians (designated by a box and the letter "I") are included in the fee schedule and are used to calculate maximum fees payable.

(6) Unit values given in the Relative Values for Physicians section titled "HCPCS Codes" are not included in the fee schedule; services listed in this section are considered to have unit values of "RNE" (relativity not established) for purposes of maximum fee calculation.

(7) All instructions, definitions, guidelines, and other explanations given in the most current edition including updates of the RVP, affecting the determination of individual fees, except as specifically revised or deleted by the department, apply.

(8) Revisions to the conversion factors contained in the Medical Fee Schedule become effective January 1 except as otherwise provided for in these rules. An insurer is not obligated to pay more than the fee provided by the Medical Fee Schedule for a service provided within the state of Montana. The conversion factor in effect on the date the service is provided must be used to calculate the fee.

(9) The maximum fee that an insurer is required to pay for a particular procedure is computed by the unit value times the conversion factor except as otherwise provided for in these rules. Use the conversion factor approved by the department for each specialty area. For example, if the conversion factor is $5.00, and a procedure has a unit value of 3.0, the most that the insurer is required to pay the provider for that procedure is $15.00.

(10) Where a procedure is not covered by these rules, the insurer must pay a reasonable fee, not to exceed the usual and customary fee charged by the provider to non-workers' compensation patients unless the procedure is not allowed by these rules.

(11) Where a unit value is listed as "BR", it means that the fee is calculated on a "by report" basis. The fee charged is to be reasonable, and may not exceed the usual and customary fee charged by the provider to non-workers' compensation patients.

(12) It is the responsibility of the provider to use the proper procedure code(s) on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02.)

Rules 24.29.1533 through 24.29.1535 reserved

24.29.1536 CONVERSION FACTORS--METHODOLOGY (1) Except as provided by ARM 24.29.1537, conversion factors shall be established annually by the department by increasing the conversion factors from the preceding year by the percentage increase in the state's average weekly wage. If for any year the state's average weekly wage does not increase, the rates will be held at the existing level until there is a net increase in the state's average weekly wage.

(2) Beginning in 1994 the special procedure codes and descriptions may be updated by the department as necessary to maintain the most current procedural terminology. Updates may include the addition or deletion of individual procedures or the revision of individual procedure codes or descriptions. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2002 MAR p. 1758, Eff. 7/1/02.)

24.29.1537 SPECIAL MONITORING AND ADJUSTMENT OF PHYSICAL MEDICINE FEES DURING THE PERIOD JULY 1, 2002 THROUGH DECEMBER 31, 2003 (1) During the period from July 1, 2002 through December 31, 2003, the physical medicine conversion factor will be adjusted on January 1, April 1, July 1, and October 1, 2003, as needed to keep the average cost-per-visit for physical medicine services in line with expected costs. The expected average cost-per-visit amount for the July 1, 2002 through December 31, 2003, period has been determined using state compensation insurance fund data. State compensation insurance fund data will continue to be used to monitor the actual average cost-per-visit during the period.

(2) If after July 1, 2002, the average cost-per-visit for physical and occupational therapy services varies more than 1% from the average cost-per-visit of $77.74, the conversion factor will be adjusted according to the following process:

(a) An adjustment to the conversion factor for the physical and occupational therapy specialties will be made on January 1, 2003, using the actual average cost-per-visit for the period of July 1, 2002, through September 30, 2002. A second adjustment may be made on April 1, 2003, using the actual average cost-per-visit for the period of July 1, 2002, through December 31, 2002. Subsequent adjustments may be made every three months using three additional months of data to determine the actual average cost-per-visit. If the average cost-per-visit remains between $76.96 and $78.52 during 2002 and $76.96 and $78.52 (plus any percentage increase in the 2003 average weekly wage), then no adjustment will be made to the conversion factor. If an adjustment is necessary, the new conversion factor will be calculated by determining the actual average cost-per-visit for the period and dividing it by the conversion factor in effect for the period to arrive at the average RVP units per visit. Dividing the target average cost-per-visit by the average RVP units per visit determines the adjusted conversion factor.

(i) As an example, assume an actual average cost-per-visit for the period of July 1, 2002 through September 30, 2002 to be $70.75. The actual average cost-per-visit amount of $70.75 is divided by $4.25 (the conversion factor in effect for the period) to arrive at a quotient of 16.65 (average RVP units per visit). The target average cost-per-visit of $77.74 is divided by 16.65 units to generate the new conversion factor of $4.67 for the period beginning January 1, 2003. That new conversion factor would also be increased by the percentage increase in the state's average weekly wage for 2003, if any, and would be adopted effective January 1, 2003.

(ii) As another example, if the actual average cost-per-visit for the period of January 1, 2003, through September 30, 2003, remains between $76.96 and $78.52 (as increased by the percentage increase in the state's average weekly wage for 2003), then no additional adjustments will be made until January 1, 2004.

(b) On or after January 1, 2004, the conversion factors for occupational and physical therapy services will increase as provided by ARM 24.29.1536.

(3) If after July 1, 2002, the average cost-per-visit for chiropractic services exceeds the 2002 average cost-per-visit target of $62.90, or the 2003 average cost-per-visit target of $62.90 plus any percentage increase in the 2003 average weekly wage, the conversion factor for specialty codes 98940 through 98943, 99201 through 99204, and 99211 through 99214 will be adjusted according to the following process:

(a) An adjustment to the conversion factor for the chiropractic specialty area will be made on January 1, 2003 using the actual average cost-per-visit for the period of July 1, 2002 through September 30, 2002. A second adjustment may be made on April 1, 2003, using the actual average cost-per-visit for the period of July 1, 2002, through December 31, 2002. Subsequent adjustments may be made every three months using three additional months of data to determine the actual average cost-per-visit. If the average cost-per-visit remains below $62.90 during 2002, or below $62.90 (plus the percentage increase in the 2003 average weekly wage) for 2003, then no adjustment will be made to the conversion factor. If an adjustment is necessary, the new conversion factor will be calculated by determining the actual average cost-per-visit for the period and dividing it by the conversion factor in effect for the period to arrive at the average RVP units per visit. The percentage of the RVP units attributable to usage of the codes specified in (3) and all other CPT codes utilized during the period must then be determined. The percentage of the units other than those specified in (3) is multiplied by the average RVP units per visit and the product multiplied by the conversion factor in effect for those codes and subtracted from the target average cost-per-visit. The difference is then divided by the remaining average RVP units per visit attributable to the codes specified in (3). The quotient is the adjusted conversion factor.

(i) As an example, assume an average cost-per-visit for the period of July 1, 2002, through September 30, 2002, to be $69.60. Also assume a distribution of 91.59% for the codes specified in (3) and 8.41% for all others. Actual average cost-per-visit amount of $69.60 is divided by $4.25 (the conversion factor in effect for the period) to arrive at a quotient of 16.38 (average RVP units per visit). The 16.38 units are multiplied by 8.4%, resulting in a product of 1.38 units, which are then multiplied by $4.25 (the conversion factor in effect), resulting in a second product of $5.87. The $5.87 is then subtracted from the target average cost-per-visit of $62.90, yielding a difference of $57.03. The $57.03 is then divided by the remaining 15.00 units (16.38 units minus 1.38 units) to arrive at the adjusted conversion factor of $3.80 for the period beginning January 1, 2003. That new conversion factor of $3.80 would also be increased by the percentage increase in the state's annual average weekly wage for 2003, if any, and would be adopted effective January 1, 2003.

(ii) As another example, if the actual average cost-per-visit remains below the target rate for the period of October 1, 2002 through September 30, 2003, then no additional adjustments will be made until January 1, 2004.

(b) On and after January 1, 2004, the conversion factors for chiropractic services will increase as provided by ARM 24.29.1536.

(4) The conversion factor for all other codes that doctors of chiropractic are authorized to use under ARM 24.29.1572, with the exception of radiology codes, will remain at the rate received by providers licensed as occupational therapists and physical therapists. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02.)

Rules 24.29.1538 through 24.29.1540 reserved

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24.29.1541 ACUPUNCTURE FEES (1) Fees for acupuncture are payable only for the procedure codes listed in subsection (4), below, according to the unit values listed. None of the procedure codes, descriptions, or unit values in Relative Values for Physicians apply to acupuncture.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends upon the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for acupuncture specialty area services is $3.77.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) The following special procedure codes, with the associated description and unit values, are recognized for acupuncture specialty area services:

	Procedure Code	Description	Unit Value
(a)	96300	Acupuncture; initial visit and treatment	8.0
(b)	96301	each subsequent visit	8.0

(History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-704 MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94.)

Rules 24.29.1542 through 24.29.1550 reserved

24.29.1551 DENTAL SPECIALTY AREA FEES (1) Fees for dental medical specialty area services are payable only for the procedure codes listed in subsection (4), below, according to the unit values listed. None of the procedure codes, descriptions, or unit values in Relative Values for Physicians apply to dental services.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for dental specialty area services, procedure codes D0110 through D9960 is $7.27.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) Effective April 1, 1993, the following schedule of procedure codes, with the associated description and unit values, are recognized for the dental service areas:

	Procedure Code	Description	Unit Value
(a)	D0110	Initial oral examination	1.8
	D0120	Periodic oral examination	2.0
	D0130	Emergency oral examination	2.1
(b)	D0210	Intraoral--complete series	5.2
	D0220	Intraoral--periapical, first film	0.9
	D0230	Intraoral--periapical, each additional film	0.7
	D0272	Bitewings--two films	1.6
	D0274	Bitewings--four films	2.1
(c)	D0321	Other temporomandibular joint films	BR
	D0330	Panoramic film	4.7
	D0340	Cephalometric film	5.2
(d)	D0460	Pulp vitality tests	1.4
	D0470	Diagnostic casts	4.1
	D0471	Diagnostic photographs	2.4
(e)	D1110	Prophylaxis--adult	4.1
(f)	D2140	Amalgam--one surface, permanent	4.4
	D2150	Amalgam--two surfaces, permanent	4.5
	D2160	Amalgam--three surf., permanent	9.4
	D2161	Amalgam--four or more surf., perm.	8.2

(g)	D2330	Resin--one surface			4.5
	D2331	Resin--two surfaces			7.1
	D2332	Resin--three surfaces		8.1	
	D2335	Resin--four or more surfaces or involving incisal angle	10.6		
(h)	D2740	Crown--porcelain/ceramic substrate	45.8		
	D2750	Crown--single restoration only--porcelain fused to high noble metal	42.3		
	D2751	Crown--single restoration only--porcelain fused to predominantly base metal	44.1		
	D2752	Crown--single restoration only--porcelain fused to noble metal	45.7		
	D2790	Crown--full cast high noble metal	41.4		
(i)	D2810	Crown--3/4 cast metallic	41.1		
(j)	D2950	Crown build-up, including any pins			6.3
	D2951	Pin retention--per tooth, in addition to restoration	0.9		
	D2952	Cast post and core in addition to crown	14.8		
	D2954	Prefabricated post and core in addition to crown		8.7	
	D2970	Temporary (fractured tooth)		5.0	
(k)	D3220	Therapeutic pulpotomy (excluding final restoration)		6.7	
(l)	D3310	Endodontic treatment--one canal (excluding final restoration)	20.0		
	D3320	Endodontic treatment--two canals (excluding final restoration)	26.7		
	D3330	Endodontic treatment--three canals (excluding final restoration)	27.6		
(m)	D3410	Apicoectomy (per tooth)--first root	17.8		
(n)	D5110	Complete upper dentures		52.9	
	D5120	Complete lower dentures			67.5
(o)	D5211	Upper partial--acrylic base (including any conventional clasps and rests)	22.0		
	D5213	Upper partial--predominantly base cast base with acrylic		55.8	

saddles (including any conventional clasps and rests)

(p) D5640 Replace broken teeth--per tooth 4.7

(q) D5820 Temporary partial--stayplate denture (upper) 20.6

(r) D6210 Pontic--cast high noble metal 52.1

D6240 Pontic--porcelain fused to high noble metal 38.9

D6241 Pontic--porcelain fused to predominantly base metal 37.0

D6242 Pontic--porcelain fused to noble metal 41.1

D6251 Pontic--resin with predominantly base metal 48.4

(s) D6750 Bridge retainers--crown--porcelain fused to high noble metal 38.9

D6751 Bridge retainers--crown--porcelain fused to predominantly base metal 37.0

D6752 Bridge retainers--crown-- 41.1

		porcelain fused to noble metal	
(t)	D7110	Single tooth extraction	4.7
	D7120	Each additional tooth extraction	4.1
(u)	D7210	Surgical removal of erupted tooth requiring elevation of muco-periosteal flap and removal of bone and/or section of tooth	9.0
	D7250	Surgical removal of residual tooth roots (cutting procedure)	7.8
(v)	D7880	Occlusal orthotic appliance	33.5
(w)	D8999	Unspecified orthodontic procedure	BR
(x)	D9110	Palliative (emergency) treatment of dental pain--minor procedures	2.4
(y)	D9220	General anesthesia	14.5
(z)	D9951	Occlusal adjustment--limited	3.8
	D9952	Occlusal adjustment--complete	5.9
	D9961	Special reports such as insurance forms, or the review of dental data to clarify a patient's status--more than information conveyed in the usual reports.	BR

(History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-704 MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94.)

Rules 24.29.1552 through 24.29.1560 reserved

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24.29.1561 PHYSICIAN FEES -- MEDICINE (1) Fees for medicine specialty area services are payable according to the values listed in Relative Values for Physicians.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for each medical specialty area service performed by a doctor of medicine, doctor of osteopathy, and doctor of podiatry are as follows:

	Specialty Area	Procedure Codes	Conversion Factor
(i)	Medicine	90000 - 99999	$ 3.77
(ii)	Surgery	10000 - 69999	80.55
(iii)	Radiology	70000 - 79999 (Professional or Total Component)	15.59
(iv)	Pathology	80000 - 89999	13.50

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536. (History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-704 MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 1659, Eff. 8/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94.)

Rules 24.29.1562 through 24.29.1565 reserved

24.29.1566 PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA (1) Except as otherwise provided by this rule, fees for the anesthesia medical specialty area are payable according to the values listed in Relative Values for Physicians. Special unit value rules listed in subsections (4) and (5), below, are established for anesthesia. Those special unit value rules supersede the corresponding unit values listed in Relative Values for Physicians, and apply to all providers. A physician who furnishes other medical services in addition to anesthesia must use the fee schedule that applies to the services rendered.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for anesthesia specialty area services is $28.97.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) Time values for anesthesia specialty area services are calculated according to the Value Guidelines given at the beginning of the RVP Surgery/Anesthesia section, except the extra minutes after multiples of 15 (or 10) may be assigned fractions of a whole unit. For example, a total anesthesia time of 2 hours 20 minutes would have a prorated unit value of 9.3 (9 units for the first 2 hours 15 minutes, and .3 units for the remaining 5 minutes).

(5) Fees for the following anesthesia specialty area services are calculated using basic values only and the addition of time units is not allowed:

(a) Pulmonary Function Testing, procedure codes 94000 through 94799.

(b) Therapeutic and diagnostic services, including nerve blocks, which includes the following codes: 20550, 31500, 36400, 36420, 36425, 36488, 36489, 36490, 36491, 36600, 36620, 36625, 36660, 62270, 62273, 62274, 62276, 62277, 62278, 62279, 62280, 62282, 62288, 62289, 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64417, 64418, 64420, 64421, 66425, 64430, 64435, 64440, 64441, 64445, 64450, 64505, 64508, 64510, 64520, 64530, 64600, 64605, 64610, 64620, 64630, 64640, 64680, 92960, 93503, and any other procedure codes that RVP identifies as "not appropriate for time units". (History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-704 MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94.)

Rules 24.29.1567 through 24.29.1570 reserved

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24.29.1571 CHIROPRACTIC FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993 THROUGH JUNE 30, 2002 (1) Except as otherwise provided by this rule, fees for medical specialty area services rendered by chiropractors from April 1, 1993 through June 30, 2002 are payable only for the procedure codes listed below, according to the unit values listed. None of the procedure codes, descriptions, or unit values in Relative Values for Physicians apply to chiropractic services other than diagnostic x-rays.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for services, other than diagnostic x-rays, performed by a doctor of chiropractic within the scope of practice is $3.77.

(b) Effective April 1, 1993, the conversion factor for diagnostic x-rays is $15.59.

(c) Effective January 1, 1994, and each year annually thereafter, the conversion factors will increase in the manner specified by ARM 24.29.1536.

(4) The following special procedure codes, with the associated description and unit values, are recognized for chiropractic services:

	Procedure Code	Description	Unit Value
(a)	C9201	Brief Consultation and Examination New Patient. This examination includes a brief history of the problem only, as well as inspection of the problem area, not including orthopedic and/or neurological testing. Very straightforward chiropractic decision-making involved. This is usually a self-limited or minor problem.	5.2
(b)	C9202	Limited Consultation and Examination New Patient. This includes an expanded, problem focused history with documentation of chief complaints, and nature of injury. An expanded, problem	7.6

focused examination would include documentation of at least two of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration. Presenting problems are usually of low to moderate severity involving straightforward Chiropractic decision making.

(c) C9203 Intermediate Consultation and Examination, New Patient. This includes documentation of a detailed history of chief complaints, nature of injury and past history including pre-existing conditions. A detailed examination should include documentation of at least three of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory test, reflexes, mensuration. Presenting problems are usually of moderate severity involving Chiropractic decision making of low complexity. 11.2

(d) C9204 Extended Consultation and Examination, New Patient. This includes documentation of a comprehensive history of chief complaints, nature of injury and past history, including pre-existing conditions. A comprehensive examination should include documentation of at least four of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration. Presenting problems are usually of moderate to high severity involving chiropractic decision 16.0

making of moderate severity. Procedure includes preparation of short narrative and findings.

(e) C9205 Comprehensive Consultation and Examination, New Patient. This includes documentation of a comprehensive history of chief complaints, nature of injury and past history, including pre-existing conditions. A comprehensive examination should include documentation of at least five of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration. Presenting problems are usually of moderate to high severity involving Chiropractic decision making of high complexity. Procedure includes preparation of short narrative and findings. 20.8

(f) C9211 Brief Office Visit for Evaluation and Management, Established Patient. May not require the presence of a physician. Presenting problems are usually minimal and typically 5 minutes or less are spent performing or supervising these services. 2.8

(g) C9212 Limited Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components: 4.8

(i) A problem focused history.

(ii) A problem focused examination, including documentation of at least two of the following: Inspection, range

of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration.

(iii) Straightforward chiropractic decision making. Usually, presenting problems are self limited or minor.

(h) C9213 Intermediate Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components: 7.8

(i) An expanded, problem focused history.

(ii) An expanded, problem focused examination, including documentation of at least three of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration.

(iii) Chiropractic decision making of low complexity. Usually presenting problems are of low to moderate severity.

(i) C9214 Extended Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components: 11.6

(i) A detailed history.

(ii) A detailed examination including documentation of at least four of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration.

(iii) Chiropractic decision making of moderate complexity. Usually presenting problems are of moderate to high severity. Procedure includes preparation of short narrative and findings.

(j)	C9215	Comprehensive Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components: (i) A comprehensive history. (ii) A comprehensive examination, including documentation of at least five of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration. (iii) Chiropractic decision making of high complexity. Usually, presenting complaints are of moderate to high severity. Procedure includes preparation of short narrative and findings.	17.6
(k)	C9251	Manipulation only, single area of spine (includes C9211 office visit).	5.5
	C9252	Manipulation only, two or more areas of spine (includes C9211 office visit).	8.2
	C9253	Manipulation only, single area of Spine, when billed with an office visit, C9201 - C9215.	2.7
(l)	C9261	One of the following modalities, w/o manipulation (includes a C9211 office visit): (i) hot or cold packs, (ii) traction, mechanical, (iii) electrical stimulation, (iv) vasopneumatic devices, (v) paraffin bath, (vi) microwave, (vii) whirlpool, (viii) diathermy, (ix) infrared, (x) ultraviolet, (xi) other.	3.8
	C9262	Two or more modalities, w/o manipulation (includes C9211 office visit).	4.8

	C9263	One modality, w/o manipulation, when billed with an office visit, C9201 - C9215.	1.0
	C9264	Two or more modalities, w/o manipulation, when billed with an office visit, C9201 - C9215.	2.0
(m)	C9271	Manipulation, single area of spine, w/ two or more modalities (consists of C9211 office visit, C9253 and C9264).	7.5
	C9272	Manipulation, two or more areas of spine, w/ two or more modalities (consists of C9211 office visit, C9253 and C9264).	10.2
	C9273	Manipulation, one or more areas, w/ two or more modalities, when billed with office visit C9201 - C9215.	4.7
(n)	C9399	Special reports, service not listed, (includes impairment ratings).	BR

(5) For initial visits, if it is necessary to provide intermediate, extended or comprehensive services as part of the initial evaluation process (codes C9203, C9204 or C9205), the provider must furnish to the insurer documentation of the reasons justifying that higher level of initial evaluation.

(6) For routine follow-up visits of an established patient, only the "brief office visit" level of service (code C9211) should be billed. If limited, intermediate, extended or comprehensive services are necessary (codes C9212, C9213, C9214 or C9215), the provider must furnish to the insurer documentation of the reasons justifying that higher level of office visit on a case-by-case, visit-by-visit basis.

(7) Diagnostic x-rays are to be billed using the procedure codes and unit values listed in Relative Values for Physicians. The provider must furnish to the insurer documentation of the reasons justifying the use of the diagnostic x-ray procedure(s) employed.

(8) The explanations, protocols, comments and directions for use contained in both the CPT manual and Relative Value for Physicians are to be applied to the procedure codes contained in this rule. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 1659, Eff. 8/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2002 MAR p. 1758, Eff. 7/1/02.)

24.29.1572 CHIROPRACTIC FEES FOR SERVICES PROVIDED ON OR AFTER JULY 1, 2002 (1) Beginning July 1, 2002, fees for services rendered by doctors of chiropractic are payable only for the procedure codes listed below and unless otherwise specified, are payable according to the unit values listed in the RVP. The procedure codes, descriptions, and unit values in the RVP apply to diagnostic x-rays for services provided by doctors of chiropractic.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) Except as provided by (6), the conversion factor used depends on the date the service was rendered:

(a) Effective July 1, 2002, the conversion factor for services performed by a doctor of chiropractic (other than diagnostic x-rays) within their scope of practice is set at $4.25 for services provided under (4)(a) and (b) below.

(b) Effective July 1, 2002, the conversion factor for services performed by a doctor of chiropractic (other than diagnostic x-rays) within their scope of practice is set at $4.25 for services provided under (4)(c) and (d) below.

(c) Effective July 1, 2002, the conversion factor for diagnostic x-rays performed by a doctor of chiropractic is set at $20.23.

(d) Beginning January 1, 2003, the conversion factor will be adjusted in the manner specified by ARM 24.29.1536.

(4) Only the following codes found in the RVP may be billed for chiropractic services:

(a) All physical medicine and rehabilitation codes except 97001 through 97006, 97033, and 97770 through 97781. Code 97799 may be billed only for providing the following services and requires a separate written report describing the service provided when billing for this code:

(i) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(ii) a report associated with non-physician conferences required by the payor; or

(iii) completion of a job description or job analysis form requested by the payor.

(b) Special services, procedures and report codes 99070 and 99080. A separate written report must be submitted describing the service provided when billing for these codes.

(c) Chiropractic manipulative treatment codes 98940 through 98943.

(d) Evaluation and management codes 99201 through 99204 and 99211 through 99214.

(e) All diagnostic x-ray codes. The provider must furnish to the insurer documentation of the reasons justifying the use of the diagnostic x-ray procedure(s) employed.

(5) The explanations, protocols, comments and directions for use contained in both the CPT manual and the RVP to be applied to the procedure codes contained in this rule.

(6) Effective July 1, 2002, code 97750 is payable at $26.50 per 15-minute unit for a maximum of 24 15-minute increments of service per day. Beginning January 1, 2003, and each year annually thereafter, the amount payable per 15-minute unit for code 97750 shall increase by the percentage increase in the state's annual average weekly wage. If for any year the state's average weekly wage does not increase, the rate will be held at the existing level until there is a net increase in the state's average weekly wage.

(7) When chiropractors are performing orthotics fitting and training (code 97504) or checking for orthotic/prosthetic use (code 97703), supplies and materials provided may be billed separately for each visit using CPT code 99070. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02.)

24.29.1573 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR CHIROPRACTIC SERVICES PROVIDED ON OR AFTER JULY 1, 2002

(1) Evaluations and re-evaluations may not be billed more than once every 30 days without prior authorization. For the first visit and for each 30-day evaluation, the chiropractor may charge for an office call in addition to treatment codes. For all other visits, the provider may charge only treatment codes without prior authorization.

(2) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750. Procedure code 97750 will be reimbursed at the rate specified in ARM 24.29.1572(6).

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical relative value has not been established, require prior authorization from the insurer.

(3) No more than two 15-minute units per day may be billed for each CPT code 97032, 97034, and 97035 without prior authorization. When ultrasound (CPT code 97035) and electrical stimulation (CPT code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(4) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(5) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(6) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(7) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(8) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(9) When billing for a manipulative treatment using codes 98940, 98941, 98942 or 98943, no office visit may be charged unless a modifier 25 is used for a specific evaluation and management code without prior authorization.

(10) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the chiropractor's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(11) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of a chiropractor. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(12) See ARM 24.29.1517 for additional prior authorization requirements concerning medical services provided by chiropractors. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02.)

Rules 24.29.1574 through 24.29.1580 reserved

24.29.1581 PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM APRIL 1, 1993 THROUGH JUNE 30, 2002 (1) Services rendered by occupational therapists and physical therapists from April 1, 1993 through June 30, 2002 are payable only for the procedure codes listed in (7) of this rule. None of the procedure codes, descriptions, or unit values in Relative Values for Physicians apply to occupational therapy and physical therapy services.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit their services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) The conversion factor used depends on the date the service was rendered:

(a) Effective April 1, 1993, the conversion factor for occupational therapists and physical therapists is $5.87.

(b) Effective January 1, 1994, and each year annually thereafter, the conversion factor will increase in the manner specified by ARM 24.29.1536.

(4) Occupational and physical therapists must obtain prior authorization for any of the following procedures:

(a) 97544, work hardening;

(b) 97546, work conditioning;

(c) 97750, off-site therapy;

(d) 97751, off-site equipment;

(e) 97764, job site visit; or

(f) 97770, physical capacity evaluation.

(5) The unit value for each procedure listed in (7) includes the value for the associated office visit.

(6) Where the fee for a procedure depends on the time spent by the provider, the time spent on the completion of reports is already included within the procedure code unless otherwise noted.

(7) The following special procedure codes, with the associated description and unit values, are recognized for physical medicine services:

	Procedure Code	Description	Unit Value
(a)	97010	treatment to one area; hot or cold packs	2.0
	97012	traction, mechanical	2.0
	97014	electrical stimulation (unattended)	2.0
	97016	vasopneumatic devices	2.0
	97018	paraffin bath	2.0

(b)	97020	microwave	2.0
	97022	whirlpool	2.0
	97024	diathermy	2.0
	97026	infrared	2.0
	97028	ultraviolet	2.0
(c)	97039	unlisted modality, equivalent in level of service to 97010-97028 (specify)	2.0
(d)	97050	treatment to one area involving two or more procedures from series 97010-97039	2.4
(e)	97110	treatment to one area, each visit; therapeutic exercises (teaching and supervision of exercises which will improve or enhance strength, range of motion, flexibility, and endurance, including passive, isotonic [concentric and eccentric], isometric, relaxation, posture, and endurance training)	5.6
	97112	neuromuscular reeducation (incorporating the concepts of motor control and motor learning to improve movement, balance, proprioceptive sense, kinesthetic sense, and perceptual motor skills [for example, neuromuscular treatment approaches, facilitation procedures, closed kinetic chain activities, developmental approaches, and sensory integration approaches])	5.6
	97114	functional activities (teaching of skills which will improve or enhance an individual's ability to perform functional activities [for example, bed mobility, transfers, gait, lifting, use of adaptive devices, joint protection and cognitive re-education] which are goal directed and task specific)	5.6

	97116	gait training (specific instructions in the proper patterns and components of walking and/or running; can be applied along a continuum from crutch training for very simple gait deviations to the application and instruction in complicated gait techniques for very complex gait dysfunctions)	5.6			
	97118	electrical stimulation (manual)	5.6			
(f)	97120	iontophoresis		5.6		
	97121	phonophoresis		5.6		
	97122	traction, manual		5.6		
	97124	massage				5.6
	97126	contrast baths		5.6		
	97128	ultrasound		5.6		
(g)	97130	soft tissue mobilization		5.6		
	97132	joint mobilization		5.6		
	97133	rehabilitation taping	5.6			
	97134	spray/stretch		5.6		
	97136	postural drain		5.6		
	97139	unlisted procedure, equivalent in level of service to 97110-97136 (specify)	5.6			
(h)	97200	treatment involving one or more procedures from group A below, and at least one procedure also in group B	6.8			

Group A	Group B
97010-97039	97118-97139
97118-97139	97260 (minutes n/a)
97260 (minutes n/a)	97261 (minutes n/a)
97261 (minutes n/a)	

(i)	97220	hubbard tank; each visit		7.2		
(j)	97240	individual pool therapy or hubbard tank with therapeutic exercises; each visit (practitioner-supervised exercises and activities performed in a pool to enhance flexibility, coordination, strength, and/or cardiovascular capacity where buoyancy and/or decreased weight bearing are indicated)	8.8			

	97241	group pool therapy or hubbard tank with therapeutic exercises, per person supervised; each visit	4.4
(k)	97260	manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure); one area	5.6
	97261	each additional area	2.6
(l)	97301	treatment involving one or more procedures from group A below, and at least one procedure also in group B	9.5

Group A	Group B
97110	97118-97139
97112	97260 (minutes n/a)
97114	97261 (minutes n/a)
97116	

(m)	97500	orthotics training (dynamic bracing splinting), upper extremities; each visit	6.6
(n)	97520	prosthetic training; each visit	6.6
(o)	97530	kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); each visit (mechanized/ computerized therapeutic exercise or activity to rehabilitate joint/muscle function using, for example, isokinetic, isotonic, isoinertial and/or isometric equipment)	7.4
(p)	97540	training in activities of daily living (self care skills and/or daily life management skills); each visit	6.6
	97544	work hardening; each 1 hour [an individualized, therapist-supervised, work-oriented treatment process involving the worker in simulated or actual work tasks which are structured and graded to progressively increase physical tolerances, adaptability, pacing, knowledge of task performance, body-mechanics, efficiency, endurance,	8.5

		and productivity to return-to-work goals. To be conducted only when a job has been identified for the worker to return to and specific job demands have been identified through a job analysis.] Other services are billable separately from work hardening.	
	97546	work conditioning; each 1 hour	8.5
		[an individualized, therapist-established and -supervised therapeutic exercise program which may include aerobic conditioning, education, limited work tasks and simulation, and progressive resistive functional exercises.]	
(q)	97705	orthotic/prosthetic evaluation-- deleted; to report use evaluation procedure code applicable to profession of provider	
	97708	activities of daily living evaluation--deleted; to report use evaluation procedure code applicable to profession of provider	
(r)	97719	face-to-face conference by therapist with payor representative(s) to update status of patient, upon request of payor or payor's authorized representative (content must be documented)	BR
(s)	97720	extremity testing for strength, dexterity, or stamina--deleted; to report use evaluation procedure code applicable to profession of provider	
(t)	97750	physical or occupational therapy provided outside usual location of practice	12.0
	97751	physical or occupational therapy equipment and personnel provided outside usual location of practice	12.0

	97752	muscle testing with torque curves during isometric and isokinetic exercise, mechanized or computerized evaluations with printout (includes representation in graph form of muscle-joint measurements of velocity, acceleration, power, range of motion, endurance, and work)	9.0
(u)	97762	computerized movement analysis testing--kinematic and/or kinetic (includes computerized measurement and analysis of functional human movement and the forces [velocity, acceleration, displacement, and muscle and joint reaction] involved in movement; can include interfacing or individual measurement of electromyogram muscle activity and/or force plate analysis [three-dimensional analysis of ground reaction forces during weight-bearing activities and movements])	9.0
	97764	job site visit, each 60 minutes (includes report)	12.0
(v)	97770	physical capacity evaluation, each 60 minutes, up to 6 hours (includes report) [Objective, directly observed measurement of a worker's ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator. Includes 97772 if requested along with physical capacity evaluation by insurer. Also called "physical tolerance screening", "functional capacity evaluation", "functional capacity assessment", or "work tolerance screening".]	14.0
(w)	97799	unlisted physical medicine service	BR

(x)	97800	New patient; routine level of service (one body part or localized area in otherwise generally healthy patient with few or no pre-existing conditions; service includes abbreviated history, clarifying tests, diagnosis, and limited treatment plan)	6.7
	97801	intermediate level of service (one or more body parts, areas, or systems affected in patient with significant but not complicated history or lengthy but not extended condition duration; service includes intermediate history, intermediate examination with up to three clarifying tests, diagnosis, and appropriate treatment plan)	9.9
	97802	complex level of service (two or more body parts, areas, or systems affected, complicated history, extended condition duration, severe injury, or complicating or precautionary circumstances; service includes extensive history, comprehensive examination with four or more clarifying tests, diagnosis, and comprehensive treatment plan)	13.0
(y)	97810	Established patient; routine level of level of service (see 97800)	4.0
	97811	intermediate level of service (see 97801)	6.7
	97812	complex level of service (see 97802)	9.9
(z)	97880	physical medicine supplies and durable medical equipment (including but not limited to corsets, heel lifts, lumbar rolls, ankle wraps, taping supplies, TENS electrodes, knee immobilizer or other braces, cervical collars, Thera-Band, surgical tubing, and prescription medicines)	BR

(aa)	98951	Report associated with non-physician conference, required by payor	3.4
(ab)	99085	Completion of job description or job analysis forms; initial 30 minutes	4.2
	99086	each additional 15 minutes	2.1

(History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2002 MAR p. 1758, Eff. 7/1/02.)

24.29.1582 PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED ON OR AFTER JULY 1, 2002 (1) Fees for services provided by occupational therapists and physical therapists are payable only for the procedure codes listed below and unless otherwise specified, are payable according to the unit values listed in the RVP.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit services to those which can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) Except as provided by (6), the conversion factor used depends on the date the service was rendered:

(a) Effective July 1, 2002, the conversion factor for services performed by a licensed occupational therapist, or a licensed physical therapist within their scope of practice is set at $4.25.

(b) Beginning January 1, 2003, the conversion factor will be adjusted in the manner specified by ARM 24.29.1536.

(4) Only the following codes found in the RVP may be billed for services provided by occupational therapists and physical therapists:

(a) All physical medicine and rehabilitation codes except 97033, and 97770 through 97781. Code 97033 may be billed only by physical therapists. Code 97799 may be billed only for providing the following services and requires a separate written report describing the service provided when billing for this code:

(i) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(ii) a report associated with non-physician conferences required by the payor; or

(iii) completion of a job description or job analysis form requested by the payor.

(b) Special services, procedures and report codes 99070 and 99080. A separate written report must be submitted describing the service provided when billing for these codes.

(5) The explanations, protocols, comments and directions for use contained in both the CPT manual and the RVP are to be applied to the procedure codes contained in this rule.

(6) Effective July 1, 2002, code 97750 is payable at $26.50 per 15-minute unit for a maximum of 24 15-minute increments of service per day. Beginning January 1, 2003, and each year annually thereafter, the amount payable per 15-minute unit for code 97750 shall increase by the percentage increase in the state's annual average weekly wage. If for any year the state's average weekly wage does not increase, the rate will be held at the existing level until there is a net increase in the state's average weekly wage.

(7) When physical therapists are billing code 97033 (iontophoresis), medication charges and electrode charges will each be billed separately for each visit using CPT code 99070.

(8) When occupational therapists or physical therapists are performing orthotics fitting and training (code 97504) or checking for orthotic/prosthetic use (code 97703), supplies and materials provided may be billed separately for each visit using CPT code 99070. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02.)

24.29.1583 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED BY OCCUPATIONAL THERAPISTS AND PHYSICAL THERAPISTS ON OR AFTER JULY 1, 2002 (1) Examinations and re-examinations may not be billed more than once every 30 days without prior authorization unless physician ordered. For the first visit and for each 30-day examination, the occupational therapist and physical therapist may charge for an office call in addition to treatment codes. For all other visits, the occupational therapist and physical therapist may charge only treatment codes without prior authorization. All examinations and re-examinations require a written report separate from the daily treatment note that reflects the claimant's functional status.

(2) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750. Procedure code 97750 will be reimbursed at the rate specified in ARM 24.29.1582(6).

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical relative value has not been established, require prior authorization from the insurer.

(3) No more than two 15-minute units per day may be billed for each CPT code 97032, 97034, and 97035 without prior authorization. When ultrasound (CPT code 97035) and electrical stimulation (CPT code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(4) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(5) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(6) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(7) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(8) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(9) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the therapist's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(10) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of the treating therapist. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(11) See ARM 24.29.1517 for additional prior authorization requirements concerning medical services provided by chiropractors, occupational therapists, and physical therapists. (History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02.)

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